RULES OF THE DISCOVERY HEALTH MEDICAL SCHEME
REGISTERED UNDER THE MEDICAL SCHEMES ACT NO 131 OF 1998
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ANNEXURES

1. NAME

The name of the Scheme is the Discovery Health Medical Scheme**,** hereinafter referred to as the "Scheme".

2. LEGAL PERSONA/LEGAL PROCEEDINGS

2.1 The Scheme is a body corporate, who in its own name, is capable of suing and of being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of the Medical Schemes Act, Regulations and these Rules.

2.2 Any person, whether in the capacity as Member, Beneficiary or Dependant, who intends to sue the Scheme on matters arising solely from the application of the Act or the Rules of the Scheme, shall subject to Rule 27 and Sections 47 to 50 of the Act, and notwithstanding the provisions of any other law, institute such procedures in a court within whose jurisdiction the Scheme's registered office is situated.

3. REGISTERED OFFICE

The registered office of the Scheme is situated at 1 Discovery Place, Ground Floor, The Ridge, Corner of Rivonia Road and Katherine Street, Sandton, 2196. This address is the *domicilium citandi et executandi* for the purposes of all legal proceedings. The Board may transfer its registered office to any other location in the Republic of South Africa, should circumstances so dictate.

4. DEFINITIONS

In these Rules, a word or expression defined in the Medical Schemes Act (Act 131 of 1998) bears the meaning thus assigned to it and, unless inconsistent with the context -

4.1 a word or expression in the masculine gender includes the feminine and *vice versa*;

4.2 a word in the singular number includes the plural and *vice versa*;

4.3 the expressions below have the following meanings-

4.4 **"Act"**

the Medical Schemes Act (Act No 131 of 1998), and the Regulations framed thereunder.

4.5 **"Admission date"**

the date upon which a person becomes a Member or, in respect of a Dependant, the date upon which such Dependant is registered as a Dependant in terms of these Rules or, in the case of an Employer, the date on which such Employer may participate in the Scheme in terms of these Rules.

4.6 **"Adult Dependant"**

a person other than the Spouse or life Partner of the Member who is in fact wholly or partly dependent on a Member for financial support, as verified by the Scheme, and who is registered in terms of these Rules as an Adult Dependant including, but not limited to:

4.6.1 the Child aged 21 years or more;

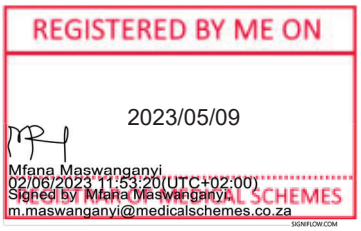
4.6.2 the divorced Spouse of a Member;

4.6.3 the immediate family member (i.e. sibling or parent) over the age of 21 in respect of whom the Member is liable for family care and support;

4.6.4 the second and any additional Spouse of a Member under a customary union according to Indigenous or Customary Law or Custom or under a union recognised as a marriage under the tenets of any religion.

4.7 **"Approval"**

prior written or telephonic approval.



4.8 **"Auditor"**

an auditor registered in terms of Section 1 of the Auditing Professional Act, 2005 and authorised by the Registrar.

4.9 **"Beneficiary"**

a Member or a person admitted as a Dependant of a Member.

4.10 **"Benefit Plan"**

the benefits which have been chosen by a Member in terms of these Rules, including but not limited to the plans that are subject to the Delta Efficiency Discount Arrangement.

4.11 **"Billing Guidelines"**

the guidelines applied to evaluate individual code submission reported in provider claims, as part of the claims adjudication process.

4.12 **"Board"**

the Board of Trustees constituted to manage the Scheme in terms of the Act and these Rules.

4.13 **"Child"**

a person's natural child, or a stepchild or legally adopted child or a child who has been placed in the custody of the Member or his Spouse or Partner in terms of an order of court or competent authority, under the age of 21 years.

4.14 **"Child Dependant"**

the Child of a Member and/or Adult Dependant, admitted as a Child Dependant in terms of these Rules.

4.15 **"Classic Direct Rate"**

the rate that the Scheme will pay a Classic Direct Provider in accordance with the undertaking referred to in clause 4.16 pursuant to which such provider's in-hospital procedures and consultations will be paid by the Scheme in full and Beneficiaries will not be required to make any further payments to him save in instances of depleted benefits.

4.16 **"Classic Direct Provider"**

a dental specialist or medical specialist who has undertaken *inter alia*, to bill Beneficiaries of the Executive Plan and Classic Plans at the Classic Direct Rate for procedures and consultations in accordance with the relevant in-hospital procedure codes and consultation codes in return for direct payment by the Scheme of benefits to which Beneficiaries are entitled.

4.17 **"Condition specific waiting period"**

a period up to 12 months during which a Beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or Treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made.

4.18 **"Continuation Member"**

a Member who retains his membership of the Scheme in terms of Rule 6.2 or a Dependant who becomes a Member of the Scheme in terms of Rule 6.3.

4.19 **"Contribution"**

in relation to a Member, the amount, exclusive of interest, paid by or in respect of the Member and his registered Dependants if any, as membership fees as set out in Annexure A of these Rules.

4.20 **"Cost"**

in relation to a benefit, the net amount payable in respect of a relevant health service.

4.21 **"Council"**

the Council for Medical Schemes as contemplated in the Act.

4.22 **"Complaint"**

A "complaint" means a complaint as defined in the Act.

4.23 **"Creditable coverage"**

any period during which a late joiner was:

4.23.1 a member or a dependant of a medical scheme;

4.23.2 a member or a dependant of an entity doing the business of a medical scheme which at the time of his/her membership of such entity, was exempt from the provisions of the Act;

4.23.3 a uniformed employee of the South African National Defence Force, or a dependant of such employee, who received medical benefits from the South African National Defence Force; or

4.23.4 a member or a dependant of the Permanent Force Continuation Fund.

4.24 **"Deductible"**

a specific payment for which a Beneficiary is personally liable, the amount of which is specifically stipulated, in terms of the Rules of the Scheme.

4.25 **"Dependant"**

4.25.1 a Member's Spouse or Partner who is not a member or a registered dependant of a member of another medical scheme;

4.25.2 a Member's Child who is not a member or a registered dependant of a member of another medical scheme;

4.25.3 an Adult Dependant as defined in Rule 4.6;

4.25.4 the immediate family of a Member (i.e. sibling or parent) in respect of whom the Member is liable for family care and support;

4.25.5 such other persons who are recognised by the Board as Dependants for purposes of these Rules.

4.26 **"Designated Service Provider"**

a healthcare provider or group of providers selected by the Scheme as preferred provider/s to provide to the Beneficiaries, diagnosis, Treatment and care in respect of one or more Prescribed Minimum Benefit conditions or any other relevant health service covered by the Scheme.

4.27 **"Discovery Health Medication Rate"**

the single exit price plus the appropriate professional fee.

4.28 **"Discovery Health Rate"/"DH Rate"**

the fee/rate as set by the Scheme in respect of the payment of relevant health services either:

4.28.1 as outlined in the Basis of Cover column of the Benefit Plan Tables (A, B and C) and Benefit Plan Schedule to these Rules as may be applicable to each Benefit Plan and if the fee/rate is set in percentage terms, the percentage is applied to the NHRPL rate (the reference price list for health services published by the Council for Medical Schemes in 2006 as may have been adjusted annually since then); or

4.28.2 in terms of an agreement between the Scheme and a service provider or group of providers.

4.29 **"Discovery network GP"**

a General Practitioner who has contracted with Discovery Health (Pty) Limited and/or the Scheme to be part of the Discovery GP network.

4.30 **"Discovery Premier Plus network GP"**

a General Practitioner who has contracted with Discovery Health (Pty) Limited and/or the Scheme to be part of the Discovery Premier Plus network.

4.31 **"Dispute"**

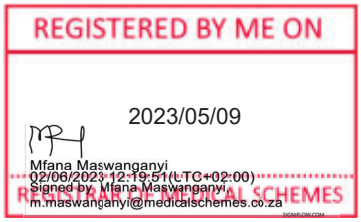
A dispute lodged in terms of Rule 27 hereof, which is a component of the internal dispute resolution mechanism of the Scheme, distinct from the regulatory complaints process in terms of the Act.

4.32 **“Efficiency Discount Arrangement”**

the network restrictions elected by Members for the purposes of attaining a discounted contribution referred herein as KeyCare Start Regional, Essential Delta Core, Essential Delta Saver, Classic Delta Core, Classic Delta Saver, Essential Delta Comprehensive and Classic Delta Comprehensive options.

4.33 **“Emergency Medical Condition”/“Emergency”**

the sudden and, at the time unexpected onset of a health condition that requires immediate medical or surgical Treatment, where failure to provide medical or surgical Treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person’s life in serious jeopardy.



4.34 **“Employee”/”Employee member”**

a person in the employment of an Employer.

4.35 **“Employer”**

a participating employer who has contracted with the Scheme for purposes of admission of its Employees as Members of the Scheme.

4.36 **“Financial year”**

the financial year of the Scheme as described in Rule 22 and as defined in the Act.

4.37 **“Fixed fee”**

a fee that covers all costs incurred by the facility for a specified procedure, including, but not limited to ward, theatre and drug costs unless otherwise specifically agreed to.

4.38 **“Frail care”**

the assistance required by persons who, due to physical or mental ailment, are wholly or partially incapable of carrying out activities associated with daily living, which activities may include attention to personal hygiene, feeding, dressing, reasonable and due attendance to personal safety and the safety of others.

4.39 **"General waiting period"**

a period in which a Beneficiary is not entitled to claim any benefits for a maximum of 3 months.

4.40 **"Global Fee"**

a fee that covers all relevant medical expenses including, but not limited to, professional, facility, radiology and pathology expenses.

4.41 **"Health Care Cover"**

Health Care Cover comprises the cover provided under a chosen Benefit Plan excluding any Personal Medical Savings Account, as outlined in the Benefit Plan Schedule.

4.42 **"Hospital Network Plans"**

refers to the following Benefit Plans: KeyCare Core, KeyCare Start, KeyCare Start Regional, KeyCare Plus, Coastal Core, Coastal Saver, Essential Delta Core, Essential Delta Saver, Classic Delta Core, Classic Smart, Essential Smart, Classic Delta Saver, Essential Delta Comprehensive and Classic Delta Comprehensive.

4.43 **"Income"**

means any amount received by or accrued to or deemed to have been received by or accrued to a Member or Member's registered Spouse/Partner by way of, including and without limitation:

4.43.1 average 12 months earnings, commission or rewards arising from employment, self-employment and employment in the informal sector or rendering services as an independent contractor;

4.43.2 interest, including capitalised interest from active and passive investments as well as dividend income from equity portfolios;

4.43.3 income from leasing of assets and/or property;

4.43.4 any distributions received from a trust, discretionary or vested, where the Member or Member's registered Spouse/Partner is a beneficiary or otherwise;

4.43.5 any financial assistance received in terms of any statutory social assistance programme;

4.43.6 any distributions received from a pension or provident fund.

4.44 **"KeyCare GP and Specialist"**

4.44.1 KeyCare GP means a general practitioner who has entered into an agreement contemplated in Rule 4.28.2 in respect of Beneficiaries on the KeyCare Core, KeyCare Start and KeyCare Plus options.

4.44.2 KeyCare Specialist means a specialist medical practitioner who has entered into an agreement contemplated in Rule 4.28.2 in respect of Beneficiaries on the KeyCare Core, KeyCare Start, KeyCare Start Regional and KeyCare Plus options.

4.45 **"Medically Necessary"**

services, care or supplies, which are appropriate and necessary and evidence-based, for evaluating or determining the symptoms, diagnosis and/or clinical management of a medical condition and/or are provided for the direct care and/or Treatment of a medical condition, provided that the level of service, care or supply–

4.45.1 meets the standard of good clinical practice amongst relevant medical practitioners practicing in the community within which the Beneficiary resides;

4.45.2 is not primarily for the convenience or comfort of the Beneficiary, the Scheme and/or the provider; and

4.45.3 is deemed to be appropriate and necessary (relative to and consistent with the Beneficiary's diagnosis or condition) to meet the healthcare needs of the Beneficiary, as may be determined by the Scheme or a health professional, multi-disciplinary committee or panel of experts appointed by the Scheme to make such a determination.

4.46 **"Member"**

a person who is admitted as a Member in terms of these Rules but does not include a Dependant.

4.47 **"Member Family"**

the Member and all the Member's registered Beneficiaries.

4.48 **"Motion"**

a written proposal formally submitted to a general meeting for discussion and possible adoption as a resolution.

4.49 **"Network Hospital"**

a hospital contracted to or nominated by the Scheme for purposes of a Hospital Network Plan.

4.50 **"Non-Network Hospital"**

a hospital not contracted to nor nominated by the Scheme for purposes of a Hospital Network Plan.

4.51 **"Officer"**

any member of the Board, Independent Board Committee member, the principal officer and any employee or other agent of the Scheme, but does not include the Auditor.

4.52 **"Partner"**

a person with whom the Member has a committed and serious relationship akin to a marriage or recognised as a union or partnership by law, based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

4.53 **"Payment in Full"**

in relation to a Prescribed Minimum Benefit, means payment according to the service provider's invoice (i.e. cost) for relevant healthcare services rendered, subject to the use of protocols, designated service providers (DSPs), formularies, pre-authorisation or such other managed care initiatives in place and provided for in these Rules.

4.54 **"Per Diem"**

a Fee based on a set rate per day.

4.55 **"Personal Medical Savings Account"**

means a personal medical savings account operated as contemplated in paragraphs 3 – 7 of Annexure B, in conjunction with the benefit rules applicable to the health plan chosen by the Member.

4.56 **"Planned Procedures"**

those medical procedures that are non-life threatening that develop over time, are not of sudden onset and where the timing of the procedure is generally

discretionary and/or elective.

4.57 **"Pre-existing condition"**

a condition for which medical advice, diagnosis, care or Treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made.

4.58 **"Preferred Provider"**

a healthcare provider or group of providers, selected by the Scheme in terms of an agreement in which the fee/rate is determined in respect of the payment of relevant health services.

4.59 **"Premier Rate"**

the rate that the Scheme will pay a Premier Rate Provider, in accordance with the undertaking referred to in Rule 4.60, pursuant to which such provider's procedures and consultations will be paid by the Scheme in full and Beneficiaries will not be required to make any further payments to him save in instances of depleted benefits.

4.60 **"Premier Rate Provider"**

a dental specialist or medical specialist who has undertaken *inter alia*, to bill Beneficiaries at the Premier Rate for procedures and consultations in accordance with the relevant procedure codes and consultation codes in return for direct payment by the Scheme of benefits to which Beneficiaries are entitled.

4.61 "**Prescribed Minimum Benefits"/"PMBs"**

the benefits contemplated in Section 29(1)(o) of the Act and consist of the provision of the diagnosis Treatment and care costs of the Diagnosis and Treatment Pairs listed in Annexure A of the Regulations to the Act, subject to any limitations specified therein.

4.62 "**Proxy"**

a Member authorised in terms of the Rules to act on behalf of another Member in circumstances where the Member is unable to attend a meeting.

4.63 **"Registrar"**

the Registrar or Deputy Registrar/s of Medical Schemes appointed in terms of Section 18 of the Act.

4.64 **"Related Account"**

is any account related to an approved in-hospital admission other than the hospital account.

4.65 **"Relevant health services"**

a service as defined in the Act which is provided for in a Benefit Plan.

4.66 **"Rules"**

these Rules of the Scheme, including the Benefit Plan schedule and Annexures.

4.67 **"Second Opinion"**

means an opinion of a health professional appointed by the Scheme. Such opinion will be based on:

4.67.1 a clinical examination of the patient/Beneficiary by such healthcare professional and/or;

4.67.2 a clinical report submitted by the Scheme to the healthcare professional.

4.68 **"Spouse"**

the spouse(s) of a Member to whom the Member is married or is in a union recognised in accordance with any law or custom or enjoys a relationship similar to that of legally married spouses.

4.69 **"Termination date"**

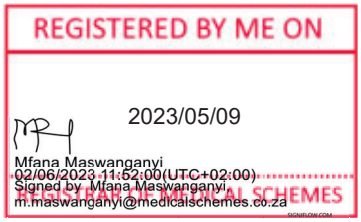
the effective date of termination of a Member's membership, Dependant's registration or an Employer's participation in terms of these Rules.

4.70 **"Treatment"**

provision of healthcare services which would include, but is not limited to hospitalisation or non-hospitalisation benefits and subject to Rule 4.45.

4.71 **"TTO"**

medication that a Beneficiary is required to take at home but is prescribed to the Beneficiary whilst in hospital by the health care professionals treating the Member in hospital.



5. BUSINESS OF A MEDICAL SCHEME

The business of the Scheme is:

5.1. to undertake liability, in respect of its Members and their Dependants, in return for a contribution or premium;

5.2. to make provision for the obtaining of any relevant health service;

5.3. to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and/or

5.4. to render a relevant health service, either by the Scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person in association with, or in terms of an agreement with, the Scheme.

6. MEMBERSHIP

6.1 **Eligibility**

Subject to Rule 8, membership is open to any person or group of persons, and shall be compulsory in respect of an Employee Member who in terms of his conditions of employment, is required to become a Member.

6.2 **Continuation of membership despite termination of employment**

6.2.1 Except in the case of voluntary resignation from the Scheme, a Member shall retain his membership of the Scheme with his registered Dependants, if any, in the event of his retiring from the service of his Employer or his employment being terminated by his Employer on account of retrenchment, age, ill health or other disability.

6.2.2 The Scheme shall inform the Member of his right to continue his membership and of the contribution payable from the date of retirement or termination of his employment.

6.3 **Dependants of deceased Members**

6.3.1 The Dependants of a deceased Member, who are registered with the Scheme as his Dependants at the time of such Member's death, shall be entitled to membership of the Scheme without any new restrictions, limitations or waiting periods.

6.3.2 The Scheme shall inform the Dependant of his right to membership and of the contributions payable in respect thereof. Unless such person informs the Board in writing of his intention not to become a Member, he shall be admitted as a Member of the Scheme.

6.3.3 Such a Member's membership terminates if he becomes a member or a dependant of a member of another medical scheme.

6.3.4 Where a Child Dependant/s has been orphaned, the eldest Child may be deemed to be the Member, and any younger siblings may be deemed to be the Child Dependant/s.

7. REGISTRATION AND DE-REGISTRATION OF DEPENDANTS

7.1 Registration of Dependants

7.1.1 A Member may apply for the registration of his Dependants at the time that he applies for membership in terms of Rule 8.

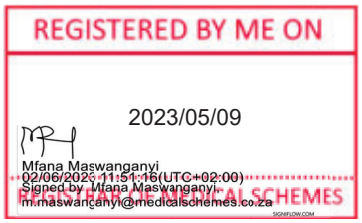
7.1.2 Registration of new born or newly adopted Child Dependant

7.1.2.1 A Member may apply to register his new born child or a newly adopted child within 90 days of birth or adoption.

7.1.2.2 If a Member makes such application within the 90 day period

7.1.2.2.1 such Child shall become a Child Dependant in good standing as from the date of birth or adoption and benefits will accrue as from such date; and

7.1.2.2.2 the Member must pay the requisite contribution in respect of such Child as from the first day of the month following the birth or adoption as the case may be.



7.1.2.3 If a Member makes an application after the 90 day period, the provisions contained in Rule 8.4 shall apply to such Child Dependant.

7.1.2.4 A new born child of a Member shall be deemed to be a Child Dependant of the Member for the period during which the mother is hospitalised and shall be entitled to benefits as per the Member's benefit option for this period, irrespective of whether an application to register has been made or not.

7.1.3 Registration of an Eligible Child Dependant

7.1.3.1 A Member may apply to register any Child as a Dependant if such Child is acquired by marriage or in terms of a court sanctioned guardianship (excluding foster relationship) or custody arrangement, within 30 days of acquiring such dependant, provided that such Child is eligible for membership to the Scheme.

7.1.3.2 If a Member makes such application within the 30 day period

7.1.3.2.1 such Child shall become a Child Dependant in good standing as from the date of marriage or court sanctioned guardianship or custody arrangement and benefits will accrue as from such date;

7.1.3.2.2 the provisions contained in Rule 8.4 shall not apply to such Child Dependant; and

7.1.3.2.3 the Member must pay the requisite contribution in respect of such Child from the date of commencement of membership.

7.1.3.3 If a Member makes an application after the 30 day period, the provisions contained in Rule 8.4 shall apply to such Child Dependant.

7.1.4 If a Member, who marries subsequent to joining the Scheme, applies within 90 days of the date of such marriage to register his Spouse as a Dependant, his Spouse shall thereupon be registered by the Scheme as a Dependant. Increased contributions shall be due as from the first day of the month of commencement of membership and benefits will accrue as from the date of commencement of membership.

7.1.5 In the event of any person becoming eligible for registration as a Dependant other than in the circumstances set out in Rules 7.1.1 to 7.1.4, the Member may apply to the Scheme for the registration of such person as a Dependant, whereupon the provisions of Rule 8 shall apply *mutatis mutandis.*

7.1.6 Foster Children

7.1.6.1 A Member may apply to register a foster child (as a Child Dependant) at any time.

7.1.6.2 If a Member makes such application –

7.1.6.2.1 such Child shall become a Child Dependant in good standing as from the date of registration and benefits will accrue as from such date;

7.1.6.2.2 the provisions contained in Rule 8.4 shall apply to such Child Dependant; and

7.1.6.2.3 the Member must pay the requisite contribution in respect of such Child as from the date of commencement of membership.

7.1.6.3 The Scheme may at any time request from the Member proof of the foster child's dependency to determine whether membership of the Child to the Scheme for reason of the foster relationship could arise and/or should continue.

7.2 **De-registration of Dependants**

7.2.1 A Member shall inform the Scheme within 30 days of the occurrence of any event, which results in any one of his Dependants no longer satisfying the conditions in terms of which he may be a Dependant.

7.2.2 When a Dependant ceases to be eligible to be a Dependant, he shall no longer be deemed to be registered as such for the purpose of these Rules or entitled to receive any benefits, regardless of whether notice has been given in terms of these Rules or otherwise.

8. TERMS AND CONDITIONS APPLICABLE TO MEMBERSHIP

8.1 A minor may become a Member with the consent of his parent or guardian.

8.2 No person may be a member of more than one medical scheme, or a dependant:

8.2.1 of more than one member of a particular medical scheme; or

8.2.2 of members of different medical schemes or;

8.2.3 claim or accept benefits in respect of himself or any of his dependants from any medical scheme in relation to which he is not a member or a dependant of a member.

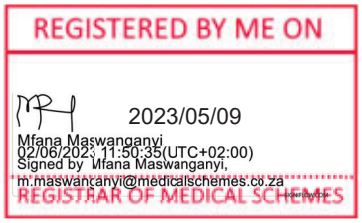
8.3 Prospective Members shall, prior to admission, complete and submit to the Scheme the application forms required by the Scheme. The Scheme may require satisfactory evidence of age, income, state of his health, dependency on the main Member and the health of his Dependants and of any medical advice, diagnosis, care or Treatment recommended or obtained within a period of 12 months immediately prior to the date on which application to the Scheme was made.

8.3.1 for the purposes of calculating contributions in respect of the KeyCare Plans, Income shall be based on the higher of the total annual Income of the Member or registered Spouse/Partner which shall be determined by regular audits and verification and/or any other third party information to verify Income;

8.3.2 where Income is provided by way of an Employer confirmation, the Scheme has the discretion to utilise such confirmation as an accurate proxy of Income;

8.3.3 Proof of any prior membership of any other medical scheme must also be submitted. The costs of any medical tests, reports or examinations that are required at the behest of the Scheme will be paid for by the Scheme. The Scheme may designate a provider to conduct such tests or examinations.

8.4 **Waiting Periods**



8.4.1 The Scheme may in respect of all conditions, including Prescribed Minimum Benefits, impose on a person in respect of whom an application is made for membership or admission as a Dependant, and where the individual was not a beneficiary of a medical scheme for a period of at least 90 days preceding the date of application:

8.4.1.1. a General waiting period of up to 3 months; and

8.4.1.2. a Condition specific waiting period of up to 12 months.

8.4.2 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of up to 24 months, terminating less than 90 days immediately prior to the date of application –

8.4.2.1 a Condition specific waiting period of up to 12 months in respect of any condition, except for any Treatment or diagnostic procedures covered within the Prescribed Minimum Benefits.

8.4.3 The Scheme may impose upon any person in respect of whom an application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme for a continuous period of more than 24 months, terminating less than 90 days immediately prior to the date of application, a General waiting period of up to 3 months, except for any Treatment or diagnostic procedures covered within the Prescribed Minimum Benefits.

8.4.4 Where the former medical scheme had imposed a General or Condition specific waiting period in respect of persons referred to in this Rule, and such waiting period had not expired at the time of termination of membership, the Scheme may impose such waiting period for the unexpired duration of a waiting period imposed by the former medical scheme.

8.5 No waiting periods may be imposed on –

8.5.1 a person in respect of whom application is made for membership or admission as a Dependant, and who was previously a beneficiary of a medical scheme, terminating less than 90 days immediately prior to the date of application, where the transfer of membership is required as a result of:

8.5.1.1 change of employment; or

8.5.1.2 an Employer changing or terminating the medical scheme of its Employees, in which case such transfer shall occur at the beginning of the Scheme's financial year, or reasonable notice must have been furnished to the Scheme by no later than 30 September to which an application is made for such transfer to occur at the beginning of the financial year.

8.5.2 a Beneficiary who changes from 1 benefit option to another within the Scheme unless that Beneficiary is subject to a waiting period on the current benefit option in which case the remaining period may be applied.

8.5.3 a Child Dependant born during the period of membership and registered in accordance with 7.1.2.

8.6 Any Dependant of a Member shall be entitled to the same benefits as the Member, provided that:

8.6.1 if the Scheme excluded the Member from a benefit in respect of a particular illness, disorder or disability which existed at the time of admission, or has limited such benefit, such exclusion or limitation shall not extend to any registered Dependant; and

8.6.2 if the Scheme has excluded a Dependant from a benefit in respect of a particular illness, disorder or disability which existed at the time of admission or has limited such benefit, such exclusion or limitation shall not extend to the Member or any other registered Dependant.

8.7 Every Member will, on request, receive a detailed summary of these Rules, which shall include contributions, benefits, limitations, the Member's rights and obligations. Members and their Dependants, and any person who claims any benefit under these Rules or whose claim is derived from a person so claiming are bound by these Rules as amended from time to time.

8.8 A Member may not cede, transfer, pledge or hypothecate or make over to any third party any claim, or part of a claim or any right to a benefit which he may have against the Scheme. The Scheme may withhold, suspend or discontinue the payment of a benefit to which a Member is entitled under these Rules, or any right in respect of such benefit or payment of such benefit to such Member, if a Member attempts to assign or transfer, or otherwise cede or to pledge or hypothecate such benefit.

8.10 Payment by a Member or his Employer or by any third party in respect of any contribution to the Scheme on behalf of the Member shall constitute the Member's acknowledgement that he is bound by these Rules and by any amendment hereto.

9. MEMBERSHIP CARD AND CERTIFICATE OF MEMBERSHIP

9.1. Every Member shall be furnished with proof of membership, containing such particulars as may be prescribed and a membership card. This proof of membership and membership card may be either physical or digital. This card must be exhibited to the supplier of a service on request. It remains the property of the Scheme and must be returned to the Scheme on termination of membership or destroyed.

9.2. A membership card may only be utilised by a Member or his registered Dependants for their own personal use. The use of a membership card other than as contemplated in this Rule is not permitted and could constitute sufficient grounds for termination of membership.

9.3. On termination of membership or on de-registration of a Dependant, the Scheme must on request, within 30 days of such termination, furnish such person with a certificate of membership and cover, containing such particulars as may be prescribed.

10. CHANGE OF ADDRESS OF MEMBER

A Member must notify the Scheme within 30 days of any change of address and other contact details, including his/her *domicilium citandi et executandi*. The Scheme shall not be held liable if a Member's rights are prejudiced or forfeited as a result of the Member's neglecting to comply with the requirements of this Rule.

11. TERMINATION OF MEMBERSHIP

11.1 Resignation

11.1.1 A Member who, in terms of his conditions of employment is required to be a Member of the Scheme, may not terminate his membership while he remains an Employee without the prior written consent of his Employer.

11.1.2 Except with the approval of the Scheme, where a Member ceases to reside in the Republic of South Africa, his membership shall terminate.

11.1.3 A Member of the Scheme who resigns from the service of his/her Employer shall be required to complete a new application for membership should they wish to continue as an individual Member of the Scheme.

11.2 Voluntary termination of membership

11.2.1 A Member, who is not required in terms of his conditions of employment to be a Member, may terminate his membership of the Scheme on giving 30 days written notice. All rights to benefits cease after the last day of membership.

11.2.2 Such notice period shall be waived in substantiated cases where membership of another medical scheme is compulsory as a result of a condition of employment.

11.2.3 A participating Employer may terminate his participation with the Scheme on giving 30 days written notice.

11.3 Death

11.3.1 In the event of death, membership of a Beneficiary terminates on the last day of the month within which he/she died.

11.4 **Failure to pay amounts due to the Scheme**

If a Member fails to pay amounts due to the Scheme, his membership may be terminated as provided in these Rules.

11.5 **Abuse of benefits, false claims, misrepresentation and non-disclosure of factual information**

11.5.1 The Board may exclude from benefits or terminate the membership of a Member or Dependant who is found to be abusing the benefits of the Scheme by presenting false claims or making a material misrepresentation or non-disclosure of factual information.

12. CONTRIBUTIONS

12.1 The total monthly contributions payable to the Scheme by a Member or in respect of a Member Family are as stipulated in Annexure A.

12.2 The contributions payable in respect of a Member Family from time to time shall be calculated by the Scheme on the basis of:

12.2.1 the Principal Member;

12.2.2 the number of Adult Dependants or Spouse(s) or Partner(s) of a Member;

12.2.3 the number of Child Dependants of a Member;

12.2.4 income as defined herein under Rule 4.43;

12.2.5 where Members have elected network restrictions for the purposes for attaining discounted contributions.

12.3 Contributions shall be due in advance or in arrears and in the manner as determined by the Scheme from time to time as it may apply per benefit option. Where contributions or any other debt owing to the Scheme have not been paid within 3 days of the due date, the Scheme shall have the right to suspend all benefit payments which have accrued to such Member during the period of default, and to give the Member and/or Employer notice that if contributions or such other debts are not paid up to date within 14 days, membership may be cancelled.

12.4 In the event that outstanding contributions or such other debt are brought up to date within the aforesaid 14-day period, benefits shall be reinstated subject to the right of the Scheme to levy a reasonable fee to cover any expenses associated with the default, and to recover interest at the prime overdraft rate of the Scheme's bankers. If such payments are not brought up to date, no benefits shall be due to the Member from the date of default and any such benefit paid may be recovered by the Scheme.

12.5 Unless specifically provided for in the Rules in respect of Personal Medical Savings Accounts, no refund of any assets of the Scheme or any portion of a contribution shall be paid to any person where such Member's membership or cover in respect of any Dependant terminates during the course of a month.

12.6 The funds contained in the Personal Medical Savings Accounts shall be dealt with in accordance with Annexure B.

12.7 In the case of termination of membership for non-disclosure of material information, contributions (or part thereof) will be refunded to the Member as from the date of inception. No refund of any contribution or any portion of a contribution shall be made on termination of membership if such termination was due to fraudulent conduct.

12.8 In the case of a Member who selects an option on which Personal Medical Savings Account benefits are available, there shall be added to his monthly contributions an amount equivalent to 15%, 20% or 25% of the total medical scheme contribution (as defined in Annexure A).

12.9 For all payments made other than via debit orders, the Member must ensure that payment is received by the Scheme.

13. LIABILITIES OF EMPLOYER AND MEMBER

13.1 The liability of the Employer towards the Scheme is limited to any amounts payable in terms of any agreement between the Employer and the Scheme and/or any agreement between the Employer and the Member.

13.2 The liability of a Member to the Scheme is limited to the amount of his unpaid contributions, together with any sum disbursed by the Scheme on his behalf or on behalf of his Dependants, which has not been repaid to the Scheme. Such liability may be recoverable from the Member by way of legal proceedings or set-off against any amounts due to the Member at any time.

13.3 In the event of a Member ceasing to be a Member, any amount still owing by such Member is a debt due to the Scheme and recoverable by it on termination of the membership or when called upon by the Scheme to do so.

14. CLAIMS PROCEDURE

14.1 Every claim submitted to the Scheme in respect of the rendering of a relevant Medically Necessary health service as contemplated in these Rules, must be accompanied by an itemised account or statement as prescribed. In order to ensure consistent and correct claims adjudication, the Scheme shall make use of practitioner-specific Billing Guidelines to ensure proper adjudication for

services rendered.

14.2 If an account, statement or claim is correct or where a corrected account, statement or claim is received, as the case may be, the Scheme must, in addition to the payment contemplated in Section 59(2) of the Act, dispatch to the Member a statement containing at least the following particulars:

14.2.1 the name and the membership number of the Member;

14.2.2 the name and practice number of the supplier of service;

14.2.3 the date of service rendered by the supplier of service on the account or statement which is covered for the service concerned;

14.2.4 the relevant code as required by the Scheme;

14.2.5 the total amount charged for the service concerned; and

14.2.6 the amount of the benefit awarded for such service.

14.3 In order to qualify for benefits, any claim received from a Member or Dependant must, unless otherwise arranged:

14.3.1 be signed and certified as correct and must be submitted to the Scheme no later than the fourth month following the date in which the service was rendered. The Scheme will have the discretion to extend the 4 month period; or

14.3.2 where the claim must be resubmitted for correction, be resubmitted within 60 days following the date during which such claim was requested to be corrected.

14.4 Where a Member or a Dependant has paid an account, he shall, in support of his claim, submit a proof of payment.

14.5 Accounts for Treatment of injuries or expenses recoverable from third parties must be supported by a statement, setting out particulars of the circumstances in which the injury or accident was sustained.

14.6 Where the Scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, for any reason whatsoever including that the Treatment rendered is not Medically Necessary, the Scheme shall notify the Member or the healthcare provider, whichever is applicable, accordingly within 30 days after receipt thereof. The Scheme shall state the reasons why such claim is erroneous or unacceptable, and afford such Member or provider the opportunity to reply or to return such corrected claim to the Scheme within 60 days thereafter.

14.7 The Scheme may at its discretion and based on justifiable reason, reject all claims in respect of services obtained from a provider where it can be shown on probable cause that such provider has placed the Scheme at risk. For purposes of giving effect to this Rule (including but not limited to financial risk such as fraud, billing irregularity, code abuse, etc.)-

14.7.1 The Scheme shall notify the provider in writing of such decision and the reason thereof. The provider is entitled to dispute the decision. The provisions of Rules 27.8 to 27.11 shall apply to the resolution of such disputes.

14.7.2 In respect of all providers who have received a notice in terms of Rule 14.7.1, the Scheme shall –

14.7.2.1 inform its Members by publishing the names of all such providers on its website; and

14.7.2.2 inform all Members who received services from such providers in the 12 month period preceding such notice, of its decision to stop payment.

14.7.3 The Scheme shall not be obliged to pay a claim made in respect of services received from a provider who receives a notice in terms of Rule 14.7.1.

14.7.4 In the event of any financial prejudice unwittingly incurred by a Member as a result of a Rule 14.7.1 decision, the Member may apply to the Scheme for a possible reimbursement consideration.

14.7.5 The Scheme may, at its discretion, at any time "lift" a notice issued in terms of Rule 14.7.1.

14.8 In any dispute as to whether a claim was properly submitted, the Member shall bear the onus of proving that the claim was submitted in accordance with these Rules.

14.9 In any dispute as to the manner of payment of the account, the healthcare provider or Member must submit notice within 120 days from date of claims payment.

14.10 If any amount which the Scheme is liable to pay in terms of these Rules is not paid timeously, then any claim which a Member may have as a result shall be a claim for specific performance against the Scheme.

15. BENEFITS

15.1. Unless membership is suspended in terms of Rule 12.3, or a waiting period is placed in terms of Rule 8, Members are entitled to benefits, outlined in the Annexures and Benefit Tables, or in accordance with the Scheme's treatment guidelines and managed care criteria and such benefits extend to all registered Dependants on the membership. A Member must, on admission, elect to participate in any one of the available benefit plans, detailed in Annexure B.

15.2. A Member is entitled to change from one to another benefit option subject to the following conditions:

15.2.1. the change may be made with effect from 01 January of any financial year provided that the Board may, in its absolute discretion, permit a Member to change from one to another benefit option on any other date;

15.2.2. application for such a change must be in writing and lodged with the principal officer at least 30 days prior to the commencement of the year in which it is intended that the change will take place, subject to the discretion of the Board of Trustees to extend this period, provided that the Member has had at least 30 days prior notification of any intended changes in benefits or contributions for the next year; and

15.2.3. The Scheme shall provide its Members with prior notification of any intended changes in benefits or contributions at least 30 days before such change is affected.

15.3. Subject to Rule 14.7, the Scheme shall, where an account has been rendered, pay any benefit due to a Member, either to that Member or to the supplier of the relevant health service who rendered the account, within 30 days of receipt of the claim pertaining to such benefit.

15.4. The Scheme may, in respect of the financial year in which a Member joins the Scheme, reduce the annual benefits *pro rata* to the period of membership in the financial year concerned, and calculated from the admission date to the end of the financial year concerned.

15.5. If, for any reason whatsoever, the Scheme pays an amount in excess of the amount which it is liable to pay in respect of a claim in terms of these Rules, then such amount shall be an amount recoverable by the Scheme by way of payments due to the Member or any such other method deemed appropriate by the Scheme.

15.6. **Third party liability**

15.6.1. In the event that a Member or Dependant requires relevant medical services in respect of an injury sustained, disease contracted or any other medical condition, for which any other person or entity (including, without limitation, the Road Accident Fund established in terms of the Road Accident Fund Act 56 of 1996 and the Compensation Fund established in terms of the Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993) is or may be held wholly or partly liable in law for compensation, damages or indemnification in terms of a statute, a contract, delict or otherwise ("the Indemnifier"), then the Member or Dependant shall be entitled to such benefits as contemplated by his or her chosen Benefit Plan and the Rules of the Scheme in addition to any other benefit they may be entitled to from such Indemnifier. Notwithstanding anything to the contrary in this Rule 15.6.1, an Indemnifier shall not include a short-term insurer or a

long-term insurer in its capacity as such.

15.6.2. The entitlement contemplated in Rule 15.6.1 does not derogate from the Member's or Dependant's right to institute a claim against the Indemnifier for compensation for the costs of any healthcare services and/or medical expenses incurred and/or which in the future may be necessitated in connection with such injury(ies) or disease(s). In the event of submitting a claim against the Indemnifier, the Member or Dependant shall -

15.6.2.1 promptly inform the Scheme of such claim submitted to the Indemnifier;

15.6.2.2 include, where applicable, in such claim all payments made by the Scheme for healthcare services rendered and/or medical expenses incurred in respect of such injury(ies) or disease(s);

15.6.2.3 advise the Scheme of any undertaking by the Indemnifier to make payment of the costs of any past and/or future healthcare services and/or medical expenses in connection with such injury(ies) and/or disease(s);

15.6.2.4 subject to Rule 15.6.2.6, reimburse the Scheme with any amount(s) paid by the Indemnifier in respect of such injury(ies) and/or disease(s) which were paid by the Scheme;

15.6.2.5 ensure that all reimbursements due to the Scheme in terms of this Rule 15.6.2 are made within 30 (thirty) days of receipt of the payment from the Indemnifier, whether the payment was made to the Member or the Member's appointed agent or to the Dependant or the Dependant's appointed agent, as the case may be; and

15.6.2.6 make all reimbursements due to the Scheme in terms of this Rule 15.6.2 without any deductions, except that in respect of non-serious claims (as defined in the Regulations to the Road Accident Fund Act of 1956), the Member or Dependant may retain 10% of the healthcare related amount paid by the Indemnifier.

15.6.3. In the event that a Member or Dependant declines to institute a claim, as contemplated in Rule 15.6.2, against an Indemnifier, then the Scheme reserves the right to institute a claim against the Indemnifier in the name of the Member or Dependant for the recovery of amount(s) paid by the Scheme to the Member and/or Dependant in respect of such injury(ies) and/or disease(s) for which the Indemnifier is liable to the Member and/or Dependant. The Member and/or Dependant undertakes to co-operate fully and timeously with the Scheme in respect of any such proceedings.

15.7. **Other insurance**

15.7.1. Any claim which at the time of its occurrence is/was covered by any other policy(ies) of insurance ("Other Insurance") which -

15.7.1.1 fully excludes cover under the Other Insurance by virtue of the Member and/or Dependant having a claim against the Scheme (i.e. where the Other Insurance includes an "escape" clause), then the Scheme will not be liable to pay the Member and/or Dependant in respect of such claim; or

15.7.1.2 provides that the cover under the Other Insurance will be in excess of the cover provided by the Scheme by virtue of the Member and/or Dependant having a claim against the Scheme (i.e. where the Other Insurance contains an "excess" clause), then any liability incurred by the Scheme in respect of such claim will be in excess of the cover provided under the Other Insurance.

15.7.2. Notwithstanding Rule 15.7.1, in the event that any request for payment is made against the Scheme by the short-term or long-term insurer(s) providing Other Insurance ("Other Insurer(s)") in respect of a claim contemplated in Rule 15.7.1, the Scheme will, if the same risk and the same interest is insured, only bear its rateable proportion of the claim (i.e. the Scheme and the Other Insurer(s) will ultimately each be liable for a percentage apportionment of the claim).

15.7.3. Any claim, other than a claim referred to in Rule 15.7.1, which at the time of its occurrence is/was covered by any Other Insurance and which results in a situation where, the same risk and the same interest is insured by the Other Insurance and the Scheme (i.e. a situation of double insurance), then the Scheme shall, where applicable, be entitled to a contribution (either prospectively or retrospectively) from the relevant Other Insurer.

15.7.4. For purposes of determining the quantum of the Scheme's liability or the Other Insurer's contribution under Rule 15.7.2 or Rule 15.7.3, as the case may be, the following provisos shall apply –

15.7.4.1 the Scheme's liability may not exceed the maximum amount applicable to the claims in terms of the chosen Benefit Plan applicable to the Member or Dependant;

15.7.4.2 any limitation, exclusion, co-payment, deductible or the like applicable to any claim shall be deducted from the Scheme's rateable proportion.

15.8. The Scheme shall be entitled to withhold payment of any claims or for any benefits that arose during the period of default as per Rule 12.3. The Scheme shall be entitled to recover from the Member any payment made to or on behalf of a Member whose contribution is unpaid, in part or in whole.

15.9. Any benefit option offered in Annexure B covers the Prescribed Minimum Benefits in accordance with Annexure 7.

15.10. The Scheme may exclude services from benefits as set out in Annexure C and Annexure 4.

15.11. The Scheme will be entitled to apply clinical policy and managed care protocols to determine Members' entitlement to benefits and to determine the application of limits and sub-limits.

15.12. **Exclusion**

The Scheme shall not pay for benefits from Health Care Cover (as contained in Annexure B) if:

15.12.1. in the reasonable opinion of a medical officer appointed for this purpose by the Scheme, taking into account generally accepted medical practice, the service/s

15.12.1.1. could have been reasonably rendered in the consulting rooms of a medical practitioner; or

15.12.1.2. could have been reasonably rendered at a lower level of care; or

15.12.1.3. are not Medically Necessary; or

15.12.1.4. were rendered to the Member or his Dependant as out-patients of the hospital concerned; or

15.12.1.5. comprise a general exclusion to the Scheme as reflected in Annexure C and Annexure 4 to these Rules; or

15.12.1.6. were rendered to the Member and his Dependants in emergency rooms of the hospital, except for Prescribed Minimum Benefit conditions; or

15.12.1.7. do not meet the protocols and clinical guidelines of the Scheme or the cover provided by the Member's Benefit Plan; or

15.12.1.8. is such that the quantum of the service comprises a Deductible.

15.13. **Review**

If hospitalisation or certain non-hospitalisation benefits ("Treatment") is recommended for a Member or a Dependant then, subject to Rules 15.15 and 15.17 below, the following provisions shall apply:

15.13.1. the Member shall give the Scheme written or verbal notice advising that such Treatment has been recommended, giving full details including the name(s) of the medical practitioner(s) who has/have made such recommendation and obtain the required authorisation from the Scheme that it will pay for the Treatment;

15.13.2. the Member shall give notice to the Scheme within such reasonable period as will allow the provisions of this Rule 15.13 to be complied with; but in any event, notice of not less than 48 hours prior to the Treatment;

15.13.3. upon receiving such notice, the Scheme shall be entitled to require the Member or his Dependant (as the case may be) to obtain a Second Opinion from a medical practitioner approved by the Scheme as to whether the recommended Treatment is necessary. The charges levied by such medical practitioner in respect of the Second Opinion shall be borne by the Scheme;

15.13.4. immediately upon obtaining such Second Opinion, the Member shall furnish the Scheme with a copy thereof; and

15.13.5. the Scheme shall, on good cause shown, be entitled to reject a request for authorisation, notwithstanding that a Second Opinion may have been furnished, if in its opinion any of the criteria stipulated in Rule 15.12 are present;

15.13.6. if the Member or Dependant (as the case may be) undergoes Treatment without the Member obtaining authorisation from the Scheme in accordance with this Rule 15.13, the Scheme's liability in respect of the Treatment of the Member or Dependant shall be subject to what is stated in Rules 15.12 to 15.17 and will further be limited to 70% of the amount for which the Scheme would have approved in terms of the relevant section of Table A.

15.14. The provisions of Rule 15.13.2 insofar as they pertain to the 48 (forty eight) hour notification period shall not apply where Treatment is required by a Member or by a Dependant as a matter of urgency. For the purposes of this Rule 15.14, Treatment shall be deemed to have been required as a matter of urgency if the Member could not have been expected to comply with the provision of Rule 15.13.2 without his health or that of his Dependant being placed in jeopardy. Notwithstanding this, the Member will be required to give the Scheme notification of the Treatment as soon as he is able.

15.15. The onus shall be upon the Member to prove that:

15.15.1. he gave notice in accordance with Rule 15.13.1;

15.15.2. such notice was given within the time period referred to in Rule 15.13.2;

15.15.3. a copy of the written Second Opinion, if required by the Scheme in accordance with Rule 15.13.3, was given to the Scheme in accordance with Rule 15.13.4;

15.15.4. Treatment was required as a matter of urgency in terms of Rule 15.14 if a dispute in respect of any such matter arises.

15.16. Pre-authorisation for Beneficiaries will take place on the following basis:

15.16.1. The Member will ensure that either the Member's family or the hospital contacts the Scheme to pre-authorise the admission.

15.16.2. All admissions are subject to pre-authorisation.

15.16.3. Where the Scheme receives a hospital claim that has not been pre-authorised payment will be limited in accordance with Rule 15.13.6.

15.16.4. The Member is obliged to make full disclosure to the Scheme during or after pre-authorisation of all healthcare services provided to the Member or Dependant even if they relate to a general scheme exclusion. Failure to do so may lead to the entire event being declined and may be regarded as a misrepresentation.

15.16.5. A pre-authorisation is not a guarantee nor a confirmation of the Scheme's obligation to make payment of a claim.

15.17. Admission for Beneficiaries on the Hospital Network Plans will take place in accordance with the following:

15.17.1. Should the Beneficiary be admitted to a Non-Network Hospital in the event of an emergency, the Beneficiary may be transferred to a Network Hospital as soon as the patient is stabilised.

15.17.2. Should the Beneficiary be admitted to a Non-Network Hospital for reasons other than an emergency and involuntariness in respect of a Prescribed Minimum Benefit, such admission will be covered up to a maximum of 80% of the benefit available to the Beneficiary on the particular Hospital Network Plan.

15.17.3. Should the Beneficiary of a Classic Delta Core, Classic Delta Saver, Classic Smart, Essential Smart, Essential Delta Core, Essential Delta Saver, Essential Delta Comprehensive or Classic Delta Comprehensive be admitted to a Non-Network Hospital for reasons other than an emergency or involuntariness, such admission will be subject to a Deductible.

15.17.4. Admissions of Beneficiaries on the KeyCare Core, KeyCare Start, KeyCare Start Regional and KeyCare Plus plans for non-emergency reasons or involuntariness to Non-Network Hospitals will not be covered save in accordance with Annexure 7.

15.17.5. Admissions of Beneficiaries on the Coastal Core and Coastal Saver plans for non-emergency reasons or involuntariness to Non-Network Hospitals will be covered up to a maximum of 70% of the benefit available to the Beneficiary on the particular Hospital Network Plan.

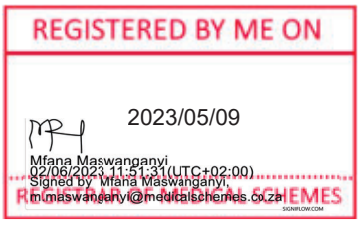
15.18. The Scheme shall only be required to fund medical technologies and Treatments not previously funded, or existing Treatments for new clinical indications, and/or unregistered medicines from Health Care Cover (as contained in Annexure B) if such medical Treatments meet the Scheme's protocols, where they exist, which shall be developed on the basis of evidence-based medicine and cost-effectiveness criteria.

15.19. Funding only for Medically Necessary healthcare services

15.19.1. The Scheme shall only fund healthcare service provided to a Member if the service in question is Medically Necessary.

15.19.2. If the Scheme reasonably determines that the healthcare service and/or level of care is not Medically Necessary, the Scheme may choose not to fund or fund such service at the appropriate or cost-effective level of care.

15.19.3. The Scheme may require a Member to be medically examined for purposes of establishing whether the healthcare service is Medically Necessary. Should the Member and/or the Member's family decline consent for such an examination, the Scheme may then, in keeping with generally accepted clinical practice and with the clinical information at hand, withdraw or reduce funding to the recommended level of care as contemplated in Rule 4.45.



15.20. Specified devices

15.20.1. In respect of a claim for a specified device, the Scheme may –

15.20.1.1. require a Member to submit a quote for the device in advance to enable the Scheme to verify the cost thereof and/or take steps to reduce its cost.

15.20.2. For purposes of this Rule, "specified device" means an external medical item as defined in Annexure 6, ventilators, hearing aids and any of the following internal devices including, but not limited to items such as cochlear implants, hearing aids and pacemakers.

16. PAYMENT OF ACCOUNTS

16.1 Payment of accounts is restricted to the maximum amount of the benefit entitlement in terms of the applicable benefit and option elected.

16.2 Subject to Rule 14.7, the Scheme may, whether or not by agreement, and in respect of any supplier or group of suppliers of a service, pay the benefit to which the Member is entitled, directly to the supplier who rendered the service.

16.3 Billing rules are the prerogative of the Scheme and this includes but is not limited to: Discovery Health Rate tariff schedule, SAMA, international practice and consultation with professional groups.

16.4 Where the Scheme has paid an account or portion of an account or any benefit to which a Member is not entitled, whether payment is made to the Member or to the supplier of service, the amount of any such overpayment is recoverable by the Scheme.

16.5 Notwithstanding the provisions of these Rules, and subject to Rule 14.7, the Scheme has the right to pay any benefit directly to the Member concerned.

16.6 The Scheme may, in its discretion, make *ex-gratia* payments to or for the benefit of a Beneficiary.

16.7 **Addresses**

16.7.1 Postal address

16.7.1.1 Any notice in connection with these Rules may be addressed to a Member or an Employer at his address stated in his application form.

16.7.2 The notice shall be deemed to have been duly given at such address:

16.7.2.1 7 days after posting to the address in Rule 16.7.1.1 if posted by prepaid registered post;

16.7.2.2 on delivery, if delivered;

16.7.2.3 on transmission, if successfully transmitted to the party's telefax number;

16.7.2.4 by e-mail if successfully sent to the party's e-mail address;

16.7.2.5 on transmission, if sent by other digital means that the Member has accepted as their method of communication.

16.7.3 Any Member or Employer shall notify the Scheme within 30 days of any change of address, by notice in writing.

16.8 **Address for service of legal documents**

16.8.1 Each Employer and Member chooses the physical address stated in his application form as the address at which documents in legal proceedings may be served.

16.8.2 Any Employer or Member may change his address for this purpose to another physical address in the Republic of South Africa, by notice in writing subject to Rule 10.

17. GOVERNANCE

17.1 The affairs of the Scheme must be managed according to these Rules by a Board of fit and proper persons (i.e. persons with the requisite character, integrity, skill, competence, financial soundness and ability to exercise a fiduciary duty) of at least 5 and a maximum of 8 persons. A Trustee shall serve a term of 4 years and shall be eligible for re-election or re-appointment. Trustees shall not serve more than 2 consecutive terms. Notwithstanding this however, a person will be entitled to serve as a Trustee for more than 2 terms in their lifetime provided that there is at least a 2 year interval between the end of the second consecutive term and the commencement of the next term. Trustees of the Scheme who were in office at 8 June 2023, by virtue of being the decision makers with regards to the extension of tenure from a 3 year to a 4 year term, shall not be eligible to benefit from extended tenure during their current trusteeship or in the event of their re-election or re-appointment to serve a second term.

17.2 The Board may co-opt a person with the requisite skills and expertise (an Independent co-opted member) to assist it in its deliberations. The Board may at any time withdraw such co-option. An Independent co-opted member shall not serve on the Board beyond the next Annual General Meeting but shall be eligible for subsequent co-option. An Independent co-opted member shall not have a vote at Board meetings.

17.3 The Board may establish committees of the Board to enable it to carry out its functions. A Board Committee may be comprised of Trustees and/or independent persons with requisite expertise (Independent Board Committee members). An Independent Board Committee member shall serve a term of 4 years and shall be eligible for re-appointment provided that such person shall not serve more than 2 consecutive terms. Notwithstanding this however, such person will be eligible to serve as an Independent Board Committee member for more than 2 terms in his lifetime provided that there is at least a 2 year interval between the end of the second consecutive term and the commencement of the next term. Independent Board Committee members shall have a vote at their respective Committee meetings.

17.4 At least half of the Trustees must be elected by Members from amongst Members.

17.5 The balance of the Trustees may be elected by Members, or appointed by incumbent Trustees provided that the Trustees appointed in terms hereof by the incumbent Trustees shall at any given time not exceed 3 Trustees.

17.6 Persons so elected/appointed must disclose annually all interests they have in relation to the Scheme/related entities, as well as on an ad hoc basis when such interests change.

17.7 The following persons are not eligible to serve as members of the Board:

17.7.1 a person under the age of 21 years;

17.7.2 an employee, director, officer, consultant, or contractor of the Administrator or the Scheme or of the holding company, subsidiary, joint venture or associate of that administrator or any other medical scheme administrator or provider of managed care services to a medical scheme;

17.7.3 a broker;

17.7.4 a person, including a legal person, associated with the administrator and/or the provider of managed care services to the Scheme;

17.7.5 the principal officer of the Scheme;

17.7.6 any employee of the Scheme;

17.7.7 the Auditor of the Scheme;

17.7.8 the legal advisors of the Scheme and of the Administrator of the

Scheme;

17.7.9 an employee, director, officer, consultant or contractor of, or any person associated with, a community pharmacy, a wholesale pharmacy, a group of pharmacies, a manufacturer of medicines and/or complementary medicines, a manufacturer of medical devices and/or medical consumables, distributor and/or wholesaler of medicines, complementary medicines, medical devices or medical consumables;

17.7.10 an employee, director, officer, consultant or contractor of a private hospital, or hospital owning or operating group, or a pathology laboratory, or pathology owning or operating group;

17.7.11 an employee, director, officer, consultant, contractor or person associated with a supplier of goods or services (including a relevant health service), to the Scheme or its administrator or to the holding company, subsidiary, joint venture or associate of its administrator, where the supply of such services and goods forms a significant percentage of the supplier's business (in excess of 25% of gross revenue shall be deemed to be "a significant percentage" of the supplier's business);

17.7.12 a person holding a Trusteeship of any other medical scheme or schemes; and

17.7.13 a person who by virtue of holding public or other office is in a position of actual or potential conflict of interest with the Scheme.

17.8 Nominations to fill vacancies, signed by the nominator and nominee in good standing, signifying his consent to stand for election, must be submitted to the Scheme by no later than 90 days prior to the Annual General Meeting. Any election duly convened must be conducted amongst the Members present in person or virtually at the Annual General Meeting of the Scheme.

17.9 The Board may appoint a Nomination Committee to assess all nominees regardless of whether such nominee is standing for election, appointment or co-option, and whether it be to the DHMS Board of Trustees or any of the established sub-committees against the eligibility criteria described in Rule 17.7 above. The Board may appoint an independent third-party service provider to assist the nomination committee in carrying out its functions.

17.9.1 In circumstances contemplated in Rule 17.16, any vacancy resulting from such termination may be filled by means of the Board appointing or co-opting a person of suitable expertise to fill the vacant position. In the case of –

17.9.1.1 an elected Trustee the tenure of such elected person shall continue until the next Trustee election. It shall thus not be necessary to convene a special election (outside of the regular cadence of elections) in order to fill the given vacancy.

17.9.1.2 of an appointed or co-opted Trustee, the tenure of this person shall be until the expiry of the tenure of the person whose position was terminated.

17.10 The remaining members of the Board may temporarily fill, by appointment any casual vacancy which occurs during its term of office, within 40 days of such vacancy arising. Such appointment will not be deemed to be an appointment as contemplated in Rule 17.5. A person so appointed shall retire at the first ensuing Annual General Meeting and that meeting shall elect a candidate to fill the vacancy.

17.11 A quorum at meetings of the Board shall be 5 members.

17.12 The Board must elect from its number the Chairperson and may elect a Vice-chairperson.

17.13 In the absence of the Chairperson and Vice-chairperson (if appointed), the Board members present must elect one of their numbers to preside.

17.14 Matters serving before the Board must be decided by a majority vote and in the event of an equality of votes, the Chairperson has a casting vote in addition to his deliberative vote.

17.15 A member of the Board may resign at any time by giving written notice to the Board. Such vacancy will be filled in terms of Rule 17.9.1.

17.16 A nominee ceases to be a nominee, or a member of the Board or sub-committee member ceases to hold office if:

17.16.1 he becomes mentally ill or incapable of managing his affairs;

17.16.2 he is declared insolvent or has surrendered his estate for the benefit of his creditors;

17.16.3 he is convicted, whether in the Republic or elsewhere, of theft, fraud, forgery or uttering of a forged document or perjury;

17.16.4 he is removed by the court from any office of trust on account of misconduct;

17.16.5 he is disqualified under any law from carrying on his profession;

17.16.6 if elected by Members of the Scheme, he ceases to be a Member of the Scheme;

17.16.7 he absents himself from 3 consecutive meetings of the Board without the permission of the Chairperson; or

17.16.8 he is removed from office by the Council in terms of Section 46 of the Act; or

17.16.9 it is subsequently determined that at the time of submitting their nomination or application, such person withheld or concealed material information which would have affected their fitness and propriety.

17.17 The Board must meet at least once every 2 months or at such intervals as it may deem necessary, but not less than 6 times in any financial year.

17.18 The Board may, discuss and resolve matters and adopt resolutions by telephone, video or electronic conferencing means, provided that the participants in such discussions are sufficient to constitute a quorum in the normal course.

17.19 The Chairperson may convene a special meeting should the necessity arise. Any two members of the Board may request the Chairperson to convene a special meeting of the Board, stating the matters to be discussed at such meeting.

17.20 Members of the Board may be reimbursed for all reasonable expenses incurred by them in the performance of their duties as Trustees.

17.21 Members of the Board are entitled to remuneration, an honorarium or any other fee in respect of services rendered in their capacity as members of the Board as determined and recommended by the Board's Remuneration Committee which will be reviewed on an annual basis and ratified by Members at the Annual General Meeting based on the approved Remuneration Policy of the Scheme.

17.22 The Board shall perform a self-assessment and a review of the performance of the Chairperson on an annual basis.

18 FIDUCIARY DUTIES OF BOARD OF TRUSTEES

18.1 The Board is responsible for the strategic oversight and sound management of the Scheme, in terms of these Rules.

18.2 The Board must act with due care, diligence, skill and in good faith.

18.3 Members of the Board must avoid conflicts of interests, and must declare any interest they may have in any particular matter serving before the Board.

18.4 The Board must apply sound business principles and ensure the financial soundness of the Scheme.

18.5 The Board shall appoint a principal officer to manage the day-to-day affairs of the Scheme, who is fit and proper to hold such office and who may appoint any staff which in its opinion is required for the proper execution of the business of the Scheme. The Board shall delegate the collective management responsibilities to the principal officer and determine the terms and conditions of service of the principal officer and of any person employed by the Scheme.

The principal officer so appointed shall execute the Board's decisions.

18.6 The Chairperson must preside over meetings of the Board and ensure due and proper conduct at meetings.

18.7 The Board must cause to be kept such minutes, accounts, entries, registers and records as are essential for the proper functioning of the Scheme.

18.8 The Board must ensure that proper control systems are employed by and on behalf of the Scheme.

18.9 The Board must ensure that adequate and appropriate information is communicated to the Members regarding their rights, benefits, contributions and duties in terms of the Rules.

18.10 The Board must take all reasonable steps to ensure that contributions are paid timeously to the Scheme in accordance with the Act and the Rules.

18.11 The Board must take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

18.12 The Board must obtain expert advice on legal, accounting, actuarial, clinical and business matters as required, or on any other matter of which the members of the Board may lack sufficient expertise.

18.13 The Board must ensure that the Rules and the operation and administration of the Scheme comply with the provisions of the Act and all other applicable laws.

18.14 The Board shall ensure that the Scheme complies with applicable laws and considers adherence to non-binding rules, codes and standards.

18.15 The Board must take steps to ensure the integrity of all documents, data and information transferred to the new administrator and/or managed care organisation, in the event of one being appointed.

18.16 The Board must take all reasonable steps to protect the confidentiality of medical records concerning any Member or Dependant's state of health.

18.17 The Board must cause to be kept in safe custody, in a safe or strong room at the registered office of the Scheme or with any financial institution approved by the Board, any mortgage bond, title deed or other security belonging to or held by the Scheme, except when in the temporary custody of another person for the purposes of the Scheme.

18.18 The Board must make such provision, as it deems desirable, and with due regard to normal practice and recommended guidelines pertaining to retention of documents, for the safe custody of the books, records, documents and other

effects of the Scheme.

18.19 The Board shall disclose annually in writing to the Registrar, any payment or considerations made to them in that particular year by the Scheme.

18.20 The Board shall ensure that the Scheme is and is seen to be a responsible corporate citizen.

18.21 The Board shall cause to be done a Board effectiveness self-assessment and such other periodic assessments as it may deem appropriate, at least every second year, with due regard to best practice and recommended guidelines so as to improve the Board's effectiveness.

18.22 The Board shall ensure that every existing and newly appointed, elected or co-opted Board member undergoes Trustee training in the form of induction training, which could include the attendance of an accredited skills programme.

19 POWERS OF BOARD

The Board has the power:

19.1 To appoint any employee required for the proper execution of the business of the Scheme, determine the terms of such appointment and where necessary to cause the termination of the services of any employee of the Scheme.

19.2 To take all necessary steps and to sign and execute all necessary documents to ensure and secure the due fulfilment of the Scheme's obligations under such appointments.

19.3 To appoint and delegate authority to a sub-committee consisting of such Board members and other experts as it may deem necessary. This committee will be responsible to provide feedback to the Board. The Board remains responsible and accountable for the fulfilment of its functions despite the appointment of any sub-committee.

19.4 To appoint a duly accredited administrator on such terms and conditions as it may determine, for the proper execution of the business of the Scheme. The terms and conditions of such appointment must be contained in a written contract which complies with the requirements of the Act and the Regulations.

19.5 To appoint, compensate (in accordance with Annexure D) and determine the levels of service of any accredited broker for the introduction or admission of a Member to the Scheme.

19.6 To appoint, contract with and compensate any accredited managed healthcare

organisations subject to the provisions of the Act and its Regulations.

19.7 To purchase movable and immovable property for the use of the Scheme or otherwise, and to sell it or any of it.

19.8 To let or hire movable or immovable property.

19.9 In respect of any monies not immediately required to meet current charges upon the Scheme and in the manner determined by the Board and in accordance with Section 35(5) of the Act and Section 30 of the Regulations to the Act, to invest or otherwise deal with such monies upon security and to realise, reinvest or otherwise deal with such monies and investments in accordance with such policy that the Board may determine from time to time which policy shall include but not be limited to meeting the requirements of Members who have opted to have the Shariah Compliant Arrangement applicable to their Benefit Plan.

19.10 With the prior approval of the Council, to borrow money for the Scheme from the Scheme's bankers against the security of the Scheme's assets for the purpose of bridging a temporary shortage.

19.11 Subject to the provisions of any law, to cause the Scheme, whether on its own or in association with any person, to establish or operate any pharmacy, hospital, clinic, maternity home, nursing home, infirmary, home for aged persons or any similar institution, in the interests of the Members of the Scheme.

19.12 To donate to any hospital, clinic, nursing home, maternity home, infirmary or home for aged persons in the interests of all or any of the Members.

19.13 To make ex-gratia payments on behalf of Members.

19.14 To contribute to any fund conducted for the benefit of employees of the Scheme.

19.15 To apply risk management tools in terms of the benefits provided for in these Rules.

19.16 To authorise the principal officer and/or such members of the Board as it may determine from time to time, and upon such terms and conditions as the Board may determine, to sign any contract or other document binding or relating to the Scheme or any document authorising the performance of any act on behalf of the Scheme.

19.17 To contribute to any association instituted for the furtherance, encouragement and co-ordination of medical schemes.

19.18 In general, to do anything which it deems necessary or expedient to perform its functions in accordance with the provisions of the Act and these Rules.

20 DUTIES OF PRINCIPAL OFFICER AND STAFF

20.1 The staff of the Scheme must ensure the confidentiality of all information regarding its Members.

20.2 The provisions of Rules 17.16.1 – 17.16.5 apply *mutatis mutandis* to the principal officer.

20.3 The principal officer is the executive officer of the Scheme and as such shall ensure that:

20.3.1 he acts in the best interests of the Scheme and all its Members at all times;

20.3.2 the decisions and instructions of the Board are executed without unnecessary delay;

20.3.3 where necessary, there is proper and appropriate communication between the Scheme and those parties, affected by the decisions and instructions of the Board;

20.3.4 he keeps the Board sufficiently and timeously informed of the affairs of the Scheme which relate to the duties of the Board as stated in Section 57(4) of the Act;

20.3.5 he keeps the Board sufficiently and timeously informed concerning the affairs of the Scheme so as to enable the Board to comply with the provisions of Section 57(6) of the Act;

20.3.6 he does not take any decisions concerning the affairs of the Scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the Scheme.

20.4 The principal officer shall be the accounting officer of the Scheme charged with the collection of and accounting for all monies received and payments authorised by and made on behalf of the Scheme in accordance with such policies, delegation of authority, directives and/or guidelines as may be determined by the Board from time to time.

20.5 The principal officer shall ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the Scheme. He shall attend all meetings of the Board, and any other duly appointed sub-committee where his attendance may be required, and ensure proper recording of the proceedings of all meetings.

20.6 The principal officer shall be responsible for the supervision of the staff employed by the Scheme unless the Board decides otherwise.

20.7 The principal officer shall keep full and proper records of all monies received and expenses incurred by, and of all assets, liabilities and financial transactions of the Scheme.

20.8 The principal officer shall prepare annual financial statements and shall ensure compliance with all statutory requirements pertaining thereto.

20.9 If the principal officer is, for a period exceeding 30 days, absent from the Republic of South Africa, or for any other reason unable to discharge any duty imposed on him by the provisions of the Act, the Scheme shall, for the duration of such absence or inability, appoint another officer in his stead.

20.10 The following persons are not eligible to be a principal officer:
20.10.1 Persons listed per Rule 17.7, with the exclusion of Rule 17.7.5.
20.10.2 A principal officer or office bearer of another medical scheme.

20.11 Any person, who, immediately prior to commencement of the Medical Schemes Amendment Act, was a principal officer of a medical scheme in contravention of Section 57(7) of this Act, will be deemed to comply with that section for the period terminating on 01 January 2004.

21 INDEMNIFICATION AND FIDELITY GUARANTEE

21.1 The Board and any Officer of the Scheme must be indemnified by the Scheme against all proceedings, costs and expenses incurred by reason of any claim in connection with the Scheme, not arising from their dishonesty or fraud.

21.2 The Board must ensure that the Scheme is insured against loss resulting from the dishonesty or fraud of any of its Officers (including members of the Board) having the receipt or charge of monies or securities belonging to the Scheme.

22 FINANCIAL YEAR OF THE SCHEME

22.1 The financial year of the Scheme extends from the 1st day of January to the 31st day of December of that year.

23 BANKING ACCOUNT

The Scheme must maintain a banking account with a registered commercial bank. All monies received must be deposited to the credit of such account and all payments must be made either by electronic transfer, tape exchange or by cheque.

24 AUDITOR AND AUDIT COMMITTEE

24.1 An Auditor (who must be authorised and approved in terms of Section 36 of the

Act) must be appointed by resolution at each Annual General Meeting, to hold office from the conclusion of that meeting to the conclusion of the next Annual General Meeting.

24.2 The Audit Committee shall be responsible for recommending the appointment of the Auditor to the Board of Trustees as well as overseeing the external audit process.

24.3 The following persons are not eligible to serve as Auditor of the Scheme:

24.3.1 A member of the Board;

24.3.2 An employee, Officer or contractor of the Scheme;

24.3.3 An employee, director, officer or contractor of the Scheme's Administrator, or of the holding company, subsidiary joint venture or associate of the Administrator;

24.3.4 A person not engaged in public practice as an Auditor; and

24.3.5 A person who is disqualified from acting as an Auditor in terms of the Companies Act, No. 71 of 2008.

24.4 Whenever for any reason an Auditor vacates his office prior to the expiration of the period for which he has been appointed, the Board must within 30 days appoint another Auditor to fill the vacancy for the unexpired period.

24.5 If the Members of the Scheme at a general meeting fail to appoint an Auditor required to be appointed in terms of this Rule, the Board must within 30 days make such appointment, and if it fails to do so, the Registrar may at any time do so.

24.6 The Auditor of the Scheme at all times has a right of access to the books, records, accounts, documents and other effects of the Scheme, and is entitled to require from the Board and the Officers of the Scheme such information and explanations as he deems necessary for the performance of his duties.

24.7 The Auditor must report to the Audit Committee of the Scheme on the accounts examined by him and on the annual financial statements laid before the Scheme in a general meeting.

24.8 The Board must appoint an Audit Committee of at least 5 members of whom at least 2 must be members of the Board and comprising a majority of members who are not officers of the Scheme.

25 GENERAL MEETINGS

25.1 Annual General Meeting

25.1.1 The Annual General Meeting of Members must be held not later than 30 June of each year.

25.1.2 The notice convening the Annual General Meeting, containing the agenda and advising how the annual financial statements, Auditor's report and annual report may be obtained, must be furnished to Members within the period specified by the Board which should not be less than 30 days before the date of the meeting. The non-receipt of such notice by a Member does not invalidate the proceedings at such meeting.

25.1.3 Only Members in good standing will be permitted to participate in the meeting on presenting proof of identity.

25.1.4 At least 15 Members of the Scheme present in person or virtually (subject to the Scheme's operational requirements on virtual participation in the given year), shall constitute a quorum. If a quorum is not present after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting must be postponed to a date determined by the Board, and Members then present constitute a quorum.

25.1.5 The annual financial statements and reports specified in Rule 25.1.2 must be laid before the meeting.

25.1.6 Notices of motions to be placed before the Annual General Meeting must reach the principal officer not later than 14 clear days prior to the date of the meeting. For purposes of the submission of a motion, reference to a clear day contemplates a 24 hour day beginning and ending at midnight. Motions must be framed in terms that are definite, concise, and free from ambiguity. A detailed motivation shall accompany the motion. Without a detailed motivation the motion will not be valid.

25.1.7 A motion at an Annual General Meeting may not deal with matters affecting the operations of the Scheme. The member concerned shall first be required to engage with the Scheme/Trustees in good faith on the subject of his/her intended motion. Matters that fall beyond the scope of an Annual General Meeting include those that affect how the Trustees may exercise their fiduciary or statutory duties, that fetter the Trustees' discretion or compel/instruct the Trustees to act (whether by commission or omission) in a predetermined manner, and where the proposed motion would be inconsistent with or in contravention of the Act or these Rules. Additionally, motions must be for the benefit of and/or in the best interest of the Scheme and its Members.

25.2 **Special General Meeting**

25.2.1 The Board may call a Special General Meeting of Members if it is deemed necessary.

25.2.2 On the requisition of at least 50 Members of the Scheme in good standing, the Board must cause a Special General Meeting to be called within 30 days of the deposit of the requisition. The requisition must state the objects of the meeting and must be signed by all the

requisitions and deposited at the registered office of the Scheme. Only those matters forming the objects of the meeting may be discussed in the meeting.

25.2.3 A motion at a Special General Meeting may not deal with matters affecting the operations of the Scheme. The proposed motion must be sufficiently urgent and such that it could not reasonably await the next Annual General Meeting. The member concerned shall first be required to engage with the Scheme/Trustees in good faith on the subject of his/her intended motion. Matters that fall beyond the scope of a Special General Meeting include those that affect how the Trustees may exercise their fiduciary or statutory duties, that fetter the Trustees' discretion or compel/ instruct the Trustees to act (whether by commission or omission) in a predetermined manner, and where the proposed motion would be inconsistent with or in contravention of the Act or these Rules. Additionally, motions must be for the benefit of and/or in the interests the Scheme and its members.

25.2.4 The notice convening the Special General Meeting, containing the agenda, must be furnished to Members at least 14 days before the date of the meeting. The non-receipt of such notice by a Member does not invalidate the proceedings at such a meeting.

25.2.5 Only Members in good standing will be permitted to participate in the meeting on presenting proof of identity.

25.2.6 At least 30 Members present in person or virtually (subject to the Scheme's operational requirements on virtual participation in the given year), shall constitute a quorum. If a quorum is not present at a Special General Meeting after the lapse of 30 minutes from the time fixed for the commencement of the meeting, the meeting is regarded as cancelled.

26 VOTING AT MEETINGS

26.1 Every Member who is in good standing and who is present at a general meeting of the Scheme, either in person or virtually (subject to the Scheme's operational requirements on virtual participation in the given year), has the right to vote, or may, subject to this Rule, appoint another Member of the Scheme who is in good standing as Proxy to attend, speak and vote in his stead.

26.2 The instrument appointing the Proxy must be in writing, in a form determined by the Board and must be signed by the Member and the person appointed as the Proxy.

26.3 Voting at meetings must be by ballot or by a show of hands. In the event of the votes being equal, the chairperson, if he is a Member, has a casting vote in addition to his deliberative vote.

27 COMPLAINTS AND DISPUTES

27.1 Any Member or provider may lodge a complaint in terms of the Act to the Registrar or a dispute to the Scheme in terms of these Rules if he is aggrieved by any decision taken by the Scheme. These Rules deal with Disputes lodged to the Scheme.

27.2 A Dispute must be lodged in writing (whether by registered post, e-mail or hard-copy delivery).

27.3 A person lodging a Dispute must do so within 3 years of the alleged service failure that gave rise to the Dispute; failing which, such person's right to lodge such Dispute shall lapse (prescribe).

27.4 The Scheme shall use its best endeavours to cause all Disputes to be processed within 30 days of its receipt; failing which, within a reasonable time.

27.5 If the Scheme finds that there is no merit in the Dispute, it must notify the person who lodged the Dispute in writing of its finding and the reasons for the finding.

27.6 If dissatisfied with the finding of the dispute, the person who lodged the Dispute may –

27.6.1 within 60 days of receiving the relevant notice, refer the Dispute in writing (by completing the appropriate Dispute Form) for adjudication by the Scheme's Dispute Committee; or

27.6.2 refer the matter as a complaint to the Registrar for consideration in terms of Section 47 of the Act.

27.7 Upon receipt of the referral in terms of Rule 27.6.1, the Scheme must convene a Dispute Committee hearing by giving notice to the person who lodged such dispute specifying -

27.7.1 the date of the hearing which may not (without the consent of the Member) be less than 21 days from the date of submitting the notice or such earlier date as the Scheme and Member may agree to;

27.7.2 the commencement time and venue for the hearing, or provision for such hearing to be held electronically;

27.7.3 who will comprise the Dispute panel;

27.7.4 the particulars of the Dispute; and

27.7.5 the procedures and the Rules to be applied when considering the Dispute, which must include the right of the person lodging such Dispute to be heard in person and/or through one or more representatives (without limitation as to expertise) at the Dispute Committee meeting.

27.8 The Dispute panel shall comprise of 3 persons appointed from the Committee established and governed in terms of Rule 27.9. At least 1 of the persons comprising a Dispute panel must be a person with legal expertise. Such person shall preside over the given Dispute Committee hearing. The decision of a Dispute panel in a given hearing shall be deemed to be a decision of the Dispute Committee.

27.9 For purposes of constituting the Dispute panel, the Scheme shall:

27.9.1 Appoint a Committee consisting of up to 12 persons (Members or non-members), for a period not exceeding 6 years, in line with the maximum tenure of Trustees. The Committee members constitute the pool of persons from whom a Dispute panel shall be constituted. Of these persons, at least one-third must be persons with legal expertise, no more than one-third may be non-members and none may be a Trustee of the Scheme, a director of the Scheme's administrator or an employee of the Scheme or its administrator;

27.9.2 Designate a person as co-ordinator of the Dispute Committee. The co-ordinator shall assume responsibility for the constituting each Dispute panel;

27.9.3 Determine the remuneration and allowance applicable to persons constituting the Dispute Committee.

27.10 A person who has lodged such Dispute and has received an adverse ruling from the Dispute Panel, has the right to appeal in terms of the Act to the Council against the decision of the Dispute Committee. The Act requires such appeal to be in the form of an affidavit directed to the Council to be furnished not later than 3 months after the date on which the Dispute Committee decision was made.

27.11 The decision of the Dispute Committee shall be final and binding unless overturned by the Council appeal process.

28 TERMINATION OR DISSOLUTION

28.1 The Scheme may be dissolved by order of a competent court or by voluntary dissolution.

28.2 Members in general meeting may decide that the Scheme must be dissolved, in which event the Board must arrange for Members to decide by ballot whether the Scheme must be liquidated. Unless the majority of Members decide that the Scheme must continue, the Scheme must be liquidated in terms of Section 64 of the Act.

28.3 Pursuant to a decision by Members taken in terms of Rule 28.2 the principal officer must, in consultation with the Registrar, furnish to every Member a

memorandum containing the reasons for the proposed dissolution and setting forth the proposed basis of distribution of the assets in the event of winding up, together with a ballot paper.

28.4 Every Member must be requested to return his ballot paper duly completed before a set date. If at least 50 per cent of the Members return their ballot papers duly completed and if the majority thereof is in favour of the dissolution of the Scheme, the Board must ensure compliance therewith and appoint, in consultation with the Registrar, a competent person as liquidator.

29 AMALGAMATION AND TRANSFER OF BUSINESS

29.1 The Scheme may, subject to the provisions of Section 63 of the Act, amalgamate with, transfer its assets and liabilities to, or take transfer of assets and liabilities of any other medical scheme or person, in which event the Board must arrange for Members to decide by ballot whether the proposed amalgamation should be proceeded with or not. The Board must call a Special General Meeting of the Scheme in order for Members to decide by ballot, at the meeting, whether the proposed amalgamation should be proceeded with or not.

29.2 If at least 50 per cent of the returned ballot papers duly completed are in favour of the amalgamation or transfer, then, subject to Section 63 of the Act, the amalgamation or transfer may be concluded.

29.3 The Registrar may, on good cause shown, ratify the conclusion of the amalgamation or transfer in the event of a lower percentage of votes, as indicated in Rule 29.2, being in favour.

30 RIGHT TO OBTAIN DOCUMENTS AND INSPECTION OF DOCUMENTS

30.1 Any Beneficiary must on request and on payment of a fee of R50 (fifty Rand) per copy, be supplied by the Scheme with a copy of the following documents:

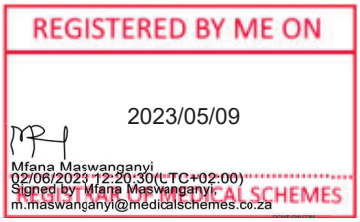
30.1.1 The Rules of the Scheme;

30.1.2 The latest audited annual financial statements, returns, Trustees' reports and Auditor's report of the Scheme;

30.1.3 The management accounts in respect of the Scheme and all of its benefit options; and

30.1.4 Protocols and formulary documents.

30.2 A Beneficiary is entitled to inspect, free of charge at the registered office of the Scheme, any document referred to in Rule 30.1 and to make extracts there from.



31 AMENDMENT OF RULES

31.1 The Board is entitled to alter or rescind any Rule or annexure or to make any additional Rule or annexure, provided that no such amendment, rescission or addition shall be valid until it has been registered by the Registrar in terms of the Act.

31.2 Should a Member's rights, obligations, contributions or benefits be amended, he/she shall be given 30 days advance notice of such change.

31.3 Notwithstanding the provisions of Rule 31.1 above, the Board must, on the request and to the satisfaction of the Registrar, amend any Rule that is accepted to be inconsistent with the provisions of the Act.

31.4 If there is any conflict between these Rules and any brochure, pamphlet, explanatory document, website, or marketing material in respect of the Scheme, the provisions of these Rules shall apply.